

		FOR OHF USE					

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0040204</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>East Side Terrace</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/00</u> to <u>12/31/00</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>3850 E. Fulton</u> <u>Decatur</u> <u>62521</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>Macon</u>			
Telephone Number: <u>(217) 422-4884</u> Fax # ()			
IDPA ID Number: <u>37-1223582004</u>			
Date of Initial License for Current Owners: <u>01/01/92</u>			
Type of Ownership:			
<input type="checkbox"/> VOLUNTARY, NON-PROFIT		<input checked="" type="checkbox"/> PROPRIETARY	
<input type="checkbox"/> Charitable Corp.		<input checked="" type="checkbox"/> Individual	
<input type="checkbox"/> Trust		<input type="checkbox"/> State	
IRS Exemption Code		<input type="checkbox"/> Partnership	
		<input type="checkbox"/> Corporation	
		<input type="checkbox"/> "Sub-S" Corp.	
		<input type="checkbox"/> Limited Liability Co.	
		<input type="checkbox"/> Trust	
		<input type="checkbox"/> Other	
In the event there are further questions about this report, please contact: Name: <u>Patrick E. Bell, CPA</u> Telephone Number: <u>(217) 465-6494</u>		(Signed) _____ (Date) _____ (Type or Print Name) <u>Scott Cornell</u> (Title) <u>Owner</u> (Signed) _____ (Date) _____ (Print Name and Title) <u>Patrick E. Bell, CPA</u> (Firm Name & Address) <u>Larsson, Woodyard & Henson, LLP</u> (Telephone) <u>(217) 465-6494</u> Fax # <u>(217) 465-6499</u>	
		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number East Side Terrace# 0040204 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	<u>16</u>	ICF/DD 16 or Less	<u>16</u>	<u>5,856</u>	6
7	<u>16</u>	TOTALS	<u>16</u>	<u>5,856</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	<u>5,398</u>			<u>5,398</u>	13
14	TOTALS	<u>5,398</u>			<u>5,398</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 92.18%

D. How many bed-hold days during this year were paid by Public Aid?

161 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)NoneF. Does the facility maintain a daily midnight census? YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?
YES ☐ NO ☒H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒I. On what date did you start providing long term care at this location?
Date started January 1, 1992

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 01/01/92 NO ☐K. Was the facility certified for Medicare during the reporting year?
YES ☐ NO ☒ If YES, enter number
of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED
CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/00 Fiscal Year: N/A

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 3

Facility Name & ID Number East Side Terrace

0040204

Report Period Beginning: 01/01/00

Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	15,950	1,087	910	17,947		17,947		17,947			1
2	Food Purchase		27,716		27,716		27,716	(481)	27,235			2
3	Housekeeping	6,259	1,079		7,338		7,338		7,338			3
4	Laundry		275		275		275		275			4
5	Heat and Other Utilities			9,170	9,170		9,170	1,291	10,461			5
6	Maintenance	8,718	1,867	3,149	13,734		13,734	(1,260)	12,474			6
7	Other (specify):*											7
8	TOTAL General Services	30,927	32,024	13,229	76,180		76,180	(450)	75,730			8
	B. Health Care and Programs											
9	Medical Director			6,900	6,900		6,900		6,900			9
10	Nursing and Medical Records	109,122	545	8,090	117,757	(1,319)	116,438	695	117,133			10
10a	Therapy			630	630		630		630			10a
11	Activities	12,769	3,241		16,010		16,010	181	16,191			11
12	Social Services			417	417		417		417			12
13	Nurse Aide Training			1,810	1,810	1,319	3,129		3,129			13
14	Program Transportation			2,659	2,659		2,659	135	2,794			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	121,891	3,786	20,506	146,183		146,183	1,011	147,194			16
	C. General Administration											
17	Administrative	10,673		18,000	28,673		28,673		28,673			17
18	Directors Fees											18
19	Professional Services			3,446	3,446		3,446		3,446			19
20	Dues, Fees, Subscriptions & Promotions			484	484		484		484			20
21	Clerical & General Office Expenses	15,519	937	21,653	38,109		38,109	(14,696)	23,413			21
22	Employee Benefits & Payroll Taxes			23,320	23,320		23,320	5,422	28,742			22
23	Inservice Training & Education											23
24	Travel and Seminar			730	730		730		730			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			6,676	6,676		6,676	872	7,548			26
27	Other (specify):*											27
28	TOTAL General Administration	26,192	937	74,309	101,438		101,438	(8,402)	93,036			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	179,010	36,747	108,044	323,801		323,801	(7,841)	315,960			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number

East Side Terrace

#0040204

Report Period Beginning:

01/01/00

Ending:

12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			7,180	7,180		7,180	14,575	21,755			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			909	909		909	339	1,248			32
33	Real Estate Taxes			4,977	4,977		4,977		4,977			33
34	Rent-Facility & Grounds			51,000	51,000		51,000	1,868	52,868			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			64,066	64,066		64,066	16,782	80,848			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			32,478	32,478		32,478		32,478			42
43	Other (specify):* Resident Supplies		407		407		407	(407)				43
44	TOTAL Special Cost Centers		407	32,478	32,885		32,885	(407)	32,478			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	179,010	37,154	204,588	420,752		420,752	8,534	429,286			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number East Side Terrace

0040204

Report Period Beginning:

01/01/00

Ending:

12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	1	2	3	
NON-ALLOWABLE EXPENSES	Amount	Refer-	OHF USE	
		ence	ONLY	
1 Day Care	\$		\$	1
2 Other Care for Outpatients				2
3 Governmental Sponsored Special Programs				3
4 Non-Patient Meals				4
5 Telephone, TV & Radio in Resident Rooms				5
6 Rented Facility Space				6
7 Sale of Supplies to Non-Patients				7
8 Laundry for Non-Patients				8
9 Non-Straightline Depreciation	3,171	30		9
10 Interest and Other Investment Income				10
11 Discounts, Allowances, Rebates & Refunds				11
12 Non-Working Officer's or Owner's Salary				12
13 Sales Tax	(481)	2		13
14 Non-Care Related Interest				14
15 Non-Care Related Owner's Transactions				15
16 Personal Expenses (Including Transportation)				16
17 Non-Care Related Fees				17
18 Fines and Penalties				18
19 Entertainment				19
20 Contributions	(100)	21		20
21 Owner or Key-Man Insurance				21
22 Special Legal Fees & Legal Retainers				22
23 Malpractice Insurance for Individuals				23
24 Bad Debt				24
25 Fund Raising, Advertising and Promotional				25
Income Taxes and Illinois Personal				
26 Property Replacement Tax				26
27 Nurse Aide Training for Non-Employees				27
28 Yellow Page Advertising				28
29 Other-Attach Schedule	(19,298)			29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ (16,708)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

	1	2	
	Amount	Reference	
31 Non-Paid Workers-Attach Schedule*	\$		31
32 Donated Goods-Attach Schedule*			32
33 Amortization of Organization & Pre-Operating Expense			33
Adjustments for Related Organization			
34 Costs (Schedule VII)	25,242		34
35 Other- Attach Schedule			35
36 SUBTOTAL (B): (sum of lines 31-35)	\$ 25,242		36
(sum of SUBTOTALS			
37 TOTAL ADJUSTMENTS (A) and (B))	\$ 8,534		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

	1	2	3	4	
	Yes	No	Amount	Reference	
38 Medically Necessary Transport.		X	\$		38
39					39
40 Gift and Coffee Shops		X			40
41 Barber and Beauty Shops		X			41
42 Laboratory and Radiology		X			42
43 Prescription Drugs		X			43
44 Exceptional Care Program		X			44
45 Other-Attach Schedule					45
46 Other-Attach Schedule					46
47 TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

East Side Terrace

ID# 00/0204

Report Period Beginning: 01/01/00

Ending: 12/31/00

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
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23			23
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70			70
71			71
72			72
73			73
74			74
75			75
76			76
77			77
78			78
79			79
80			80
81			81
82			82
83			83
84			84
85			85
86			86
87			87
88			88
89			89
90	Total	0	90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number East Side Terrace

0040204

Report Period Beginning:

01/01/00

Ending:

12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(481)	0	0	0	0	0	0	0	0	0	0	(481)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(481)	0	0	0	0	0	0	0	0	0	0	(481)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(100)	0	0	0	0	0	0	0	0	0	0	(100)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(100)	0	0	0	0	0	0	0	0	0	0	(100)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(581)	0	0	0	0	0	0	0	0	0	0	(581)	29

Summary B

12/31/00

[illegible]

Facility Name & ID Number East Side Terrace

0040204

Report Period Beginning:

01/01/00

Ending:

12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Scott Cornell	100.00	See Attached	Geneva, FL	Angela-Barr Cornell	Geneva, FL	Empl-Clerical

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	17 Admin Management	\$ 18,000	Scott Cornell	100.00%	\$ 18,000	\$	1
2	V	34 Building Rent	17,000	Scott Cornell - 1/3 ownership in lease as of 2/97	100.00%	17,000		2
3	V							3
4	V	Sch VIII						4
5	V	Central Office	19,918			19,918		5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 54,918			\$ 54,918	\$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number East Side Terrace # 0040204 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Scott Cornell	Owner	Admin.Mgmt.	100.00	72,000				\$ 18,000	17	1
2	Angela Barr-Cornell	Spouse of Owner	Salary-Clerical	0.00	37,287				9,322	21	2
3											3
4											4
5	(1) Total hours per work week		35			(3) Total hrs per week			40		5
6	Hrs devoted to Nursing Home Mgmt		35			Hours devoted to clerical			40		6
7	Hrs devoted to East Side Terrace		5.8			Hours devoted to East Side			40/5=8		7
8											8
9	(2) 5.8/35		16.6			(4) 8/40			20		9
10											10
11											11
12											12
13								TOTAL	\$ 27,422		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number East Side Terrace # 0040204 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Scott Cornell
 Street Address 311 Proctor Ct.
 City / State / Zip Code Geneva, FL 32732
 Phone Number ()
 Fax Number ()

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2	See Attached								2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number East Side Terrace# 0040204

Report Period Beginning:

01/01/00

Ending:

12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3		4		5		6		7		8		9		10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense								
		YES	NO				Original	Balance											
	A. Directly Facility Related																		
	Long-Term																		
1	First of America		X	Van	\$570.00	04/24/00	\$ 14,986	\$ 11,364	10/24/02	10.5000	\$ 909	1							
2												2							
3												3							
4	Central Office										339	4							
5												5							
	Working Capital																		
6												6							
7												7							
8												8							
9	TOTAL Facility Related					\$570.00		\$ 14,986	\$ 11,364			\$ 1,248	9						
	B. Non-Facility Related*																		
10												10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related							\$	\$			\$	14						
15	TOTALS (line 9+line14)							\$ 14,986	\$ 11,364			\$ 1,248	15						

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **East Side Terrace**# **0040204**

Report Period Beginning:

01/01/00

Ending:

12/31/00**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 1999 report.	\$	8,089	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	6,533	2
3. Under or (over) accrual (line 2 minus line 1).	\$	(1,556)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	6,533	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	4,977	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1995	7,256	8		FOR OFF USE ONLY	
	1996	7,601	9			
	1997	8,289	10	13	FROM R. E. TAX STATEMENT FOR 1999	\$
	1998	8,089	11	14	PLUS APPEAL COST FROM LINE 5	\$
	1999	6,533	12	15	LESS REFUND FROM LINE 6	\$
				16	AMOUNT TO USE FOR RATE CALCULATION	\$

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 4,400 B. General Construction Type: Exterior RBB & B/Vinyl Frame Wood Number of Stories 1

C. Does the Operating Entity? ☐ (a) Own the Facility ☒ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? ☐ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground: (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Per 93 Audit			\$ 44,534	1
2					2
3	TOTALS			\$ 44,534	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$ 210,293	\$		\$ 5,324	\$ 5,324	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Landscaping		1991		525	31	10	53	22	355	9
10	Carpet		1992		361		7			361	10
11	Landscaping		1992		2,285	135	15	152	17	1,408	11
12	Carpet		1993		294	13	10	29	16	294	12
13	Blacktop		1993		1,100	49	10	110	61	1,100	13
14	Carpet		1993		1,561	70	10	156	86	1,561	14
15	Carpet		1995		3,704		10	370	370	3,704	15
16	Carpet		1997		998	125	10	100	(25)	686	16
17	Bathroom Vinyl & Installation		1997		360	45	10	36	(9)	247	17
18	Vinyl Flooring		1998		652		10	65	65	652	18
19	Bathroom Vinyl		1999		344		10	34	34	344	19
20	Water Heater		2000		425	76	10	21	(55)	76	20
21											21
22											22
23											23
24											24
25	Central Office							6,080	6,080		25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				\$ 222,902	\$ 544		\$ 12,530	\$ 11,986	\$ 10,788	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$ 9,797	\$ 791	\$ 978	\$ 187		\$ 8,671	37
38	Current Year Purchases	625	75	30	(45)		75	38
39	Fully Depreciated Assets	9,040		700	700		9,040	39
40								40
41	TOTALS	\$ 19,462	\$ 866	\$ 1,708	\$ 842		\$ 17,786	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Transportation	1991 Chevy Pickup	1992	\$ 16,519	\$	\$	\$		\$ 16,519	42
43	Transportation	1995 Dodge Van	2000	16,986	3,397	3,397		5	3,397	43
44	Transportation	1996 Dodge Van	1997	20,602	2,373	4,120	1,747	5	17,042	44
45										45
46	TOTALS			\$ 54,107	\$ 5,770	\$ 7,517	\$ 1,747		\$ 36,958	46

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ 341,005	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 7,180	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 21,755	49 **
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ 14,575	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 65,532	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		\$	\$	\$	52
53					53
54		N/A			54
55					55
56					56
57	TOTALS	\$	\$	\$	57

G. Construction-in-Progress

	Description	Cost	
58		\$	58
59			59
60		N/A	60
61		\$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	2. CLASSROOM PORTION:	3. CLINICAL PORTION:
		IN-HOUSE PROGRAM <input checked="" type="checkbox"/>	IN-HOUSE PROGRAM <input checked="" type="checkbox"/>
		IN OTHER FACILITY <input type="checkbox"/>	IN OTHER FACILITY <input type="checkbox"/>
		COMMUNITY COLLEGE <input type="checkbox"/>	HOURS PER AIDE <u>80</u>
		HOURS PER AIDE <u>40</u>	

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$		\$	
2	Books and Supplies		1,050		1,050
3	Classroom Wages (a)	80	1,063		1,143
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)		936		936
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$ 80	\$ 3,049	\$	\$ 3,129
10	SUM OF line 9, col. 1 and 2 (e)	\$ 3,129			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	8
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	1
2. From other facilities (f)	
TOTAL TRAINED	9

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.
SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs			N/A			#VALUE!	7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$ #VALUE!	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 17

Facility Name & ID Number East Side Terrace

0040204

Report Period Beginning: 01/01/00

Ending:

12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/00

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 18,796	\$ 81,102	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	84,444	387,866	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	4,503	22,515	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 107,743	\$ 491,483	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	12,609	147,108	15
16	Equipment, at Historical Cost	73,568	265,214	16
17	Accumulated Depreciation (book methods)	(65,532)	(320,930)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 20,645	\$ 91,392	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 128,388	\$ 582,875	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 28,896	\$ 85,326	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	5,928	13,731	29
30	Accrued Salaries Payable	7,411	30,133	30
31	Accrued Taxes Payable (excluding real estate taxes)	455	4,012	31
32	Accrued Real Estate Taxes(Sch.IX-B)	6,533	24,976	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Workshop		16,667	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 49,223	\$ 174,845	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	5,436	12,409	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 5,436	\$ 12,409	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 54,659	\$ 187,254	46
47	TOTAL EQUITY(page 18, line 24)	\$ 73,729	\$ 395,621	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 128,388	\$ 582,875	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 86,973	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 86,973	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	132,860	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(146,104)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (13,244)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 73,729	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 19

Facility Name & ID Number East Side Terrace

0040204

Report Period Beginning: 01/01/00

Ending:

12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 553,602	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 553,602	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc. Income	10	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 10	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 553,612	30

2			
	Expenses	Amount	
A. Operating Expenses			
31	General Services	76,180	31
32	Health Care	146,183	32
33	General Administration	101,438	33
B. Capital Expense			
34	Ownership	64,066	34
C. Ancillary Expense			
35	Special Cost Centers	407	35
36	Provider Participation Fee	32,478	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 420,752	40
41	Income before Income Taxes (line 30 minus line 40)**	132,860	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 132,860	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number East Side Terrace

0040204

Report Period Beginning: 01/01/00

Ending:

12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			\$	\$	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses					4
5	Nurse Aides & Orderlies	10,441	11,051	83,517	7.56	5
6	Nurse Aide Trainees	161	161	1,319	8.19	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,825	1,847	12,769	6.91	9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	2,011	2,061	15,950	7.74	15
16	Dishwashers					16
17	Maintenance Workers	454	454	8,718	19.20	17
18	Housekeepers	884	884	6,259	7.08	18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	611	611	10,673	17.47	22
23	Office Manager					23
24	Clerical	702	702	15,519	22.11	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	2,080	2,080	24,286	11.68	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	19,169	19,851	\$ 179,010 *	\$ 9.02	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	26	\$ 910	1-3	35
36	Medical Director	Mo. Fee	6,900	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	203	5,010	10-3	38
39	Pharmacist Consultant	Mo. Fee	1,800	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	7	326	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	5	304	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant	10	417	12-3	45
46	Other(specify)				46
47	Dental Expense	Per Visit	320		47
48	Psyc. Consultant	Mo. Fee	960	10-3	48
49	TOTAL (lines 35 - 48)	250	\$ 16,947		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses		N/A		51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount
Anna Brackenbush	Adm.	0.00	\$ 4,984	Workers' Compensation Insurance	\$	2,742	IDPH License Fee	\$ 78
Susan Cappellin	Adm.	0.00	5,689	Unemployment Compensation Insurance		2,723	Advertising: Employee Recruitment	175
				FICA Taxes		13,542	Health Care Worker Background Check	
				Employee Health Insurance		5,422	(Indicate # of checks performed 4)	48
				Employee Meals			Dues & Subscriptions	183
				Illinois Municipal Retirement Fund (IMRF)*				
				Simple IRA		4,313		
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 10,673					
(List each licensed administrator separately.)								
B. Administrative - Other								
Description			Amount					
Scott Cornell-Admin. Mgmt.			\$ 18,000				Less: Public Relations Expense	()
							Non-allowable advertising	()
							Yellow page advertising	()
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 18,000	TOTAL (agree to Schedule V,	\$ 28,742		TOTAL (agree to Sch. V,	\$ 484
(Attach a copy of any management service agreement)				line 22, col.8)			line 20, col. 8)	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Larsson, Woodyard & Henson, LLP	Accounting		\$ 3,446				Out-of-State Travel	\$
							In-State Travel	702
							Seminar Expense	
							American Red Cross	28
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			(agree to Sch. V,	
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 3,446				line 24, col. 8)	\$ 730

* Attach copy of IMRF notifications
 SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4						N/A							
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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<p>Facility Name & ID Number East Side Terrace</p> <p>XX. GENERAL INFORMATION:</p> <p>(1) Are nursing employees (RN,LPN,NA) represented by a union? <u>NO</u></p> <p>(2) Are there any dues to nursing home associations included on the cost report? <u>NO</u> If YES, give association name and amount. _____</p> <p>(3) Did the nursing home make political contributions or payments to a political organization? <u>NO</u> If YES, have these costs been properly adjusted out of the cost report? _____</p> <p>(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? <u>NO</u> If YES, what is the capacity? _____</p> <p>(5) Have you properly capitalized all major repairs and equipment purchases? <u>YES</u> What was the average life used for new equipment added during this period? _____</p> <p>(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ <u>246</u> Line <u>10</u></p> <p>(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? <u>YES</u> If NO, attach a complete explanation. _____</p> <p>(8) Are you presently operating under a sale and leaseback arrangement? <u>NO</u> If YES, give effective date of lease. _____</p> <p>(9) Are you presently operating under a sublease agreement? YES <u>X</u> NO</p> <p>(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO <u>X</u> If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over _____</p> <p>(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ <u>32,478</u> This amount is to be recorded on line 42 of Schedule V.</p> <p>(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? <u>YES</u> If YES, attach an explanation of the allocation. _____</p>	<p style="text-align: center;">STATE OF ILLINOIS</p> <p># 0040204 Report Period Beginning: 01/01/00 Ending: 12/31/00 Page 23</p> <p>(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? <u>N/A</u></p> <p>(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? <u>NO</u> For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions</p> <p>(15) Indicate the cost of employee meals that has been reclassified to employee benefit: on Schedule V. \$ <u>N/A</u> Has any meal income been offset against related costs? _____ Indicate the amount. \$ <u>N/A</u></p> <p>(16) Travel and Transportation a. Are there costs included for out-of-state travel? <u>NO</u> If YES, attach a complete explanation. b. Do you have a separate contract with the Department to provide medical transportation for residents? <u>NO</u> If YES, please indicate the amount of income earned from such a program during this reporting period. \$ <u>N/A</u> c. What percent of all travel expense relates to transportation of nurses and patients? <u>100%</u> d. Have vehicle usage logs been maintained? <u>NO</u> e. Are all vehicles stored at the nursing home during the night and all other times when not in use? <u>YES</u> f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? <u>N/A</u> g. Does the facility transport residents to and from day training? Indicate the amount of income earned from providing such transportation during this reporting period. \$ <u>NO</u></p> <p>(17) Has an audit been performed by an independent certified public accounting firm? _____ Firm Name: <u>NO</u> The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____</p> <p>(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? <u>YES</u></p> <p>(19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? <u>N/A</u> Attach invoices and a summary of services for all architect and appraisal fees.</p>
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